

Clinical Policy: Cenegermin-bkbj (Oxervate)

Reference Number: CP.PMN.186

Effective Date: 03.01.19

Last Review Date: 02.26

Line of Business: Commercial, HIM, Medicaid

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Cenegermin-bkbj (Oxervate[™]) is recombinant human nerve growth factor (rhNGF).

FDA Approved Indication(s)

Oxervate is indicated for the treatment of neurotrophic keratitis.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation[®] that Oxervate is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Neurotrophic Keratitis (must meet all):

1. Diagnosis of stage 2 or 3 neurotrophic keratitis (*see Appendix D*);
2. Prescribed by or in consultation with an ophthalmologist or optometrist;
3. Age \geq 2 years;
4. Documented evidence of decreased corneal sensitivity (e.g., \leq 4 cm using the Cochet-Bonnet aesthesiometer, cotton swab method, CRCERT-Belmonte non-contact aesthesiometer) within the area of the PED or corneal ulcer and outside of the area of the defect in at least one corneal quadrant;
5. Disease is refractory to at least one conventional non-surgical treatment for neurotrophic keratitis (e.g., preservative-free artificial tears, gels or ointments; discontinuation of preserved topical drops and medications that can decrease corneal sensitivity; therapeutic contact lenses, botulinum induced ptosis, tarsorrhaphy, for stromal melting N-acetylcysteine, oral tetracycline, medroxyprogesterone, autologous serum tears, punctal occlusion);
6. If member previously received Oxervate, member has not received \geq 16 weeks total of Oxervate treatment per affected eye(s);
7. Dose does not exceed 1 vial per affected eye per day.

Approval duration: 8 weeks

B. Other diagnoses/indications (must meet 1 or 2):

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):

- a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
 - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Neurotrophic Keratitis (must meet all):

1. Member meets one of the following (a or b):
 - a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
 - b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B*);
 2. Member is responding positively to therapy;
 3. If member received one 8 week course of treatment and request is for a second 8 week treatment course in the same affected eye*, one of the following (a or b):
 - a. Member did not achieve complete corneal healing in the affected eye;
 - b. Member has recurrence of neurotrophic keratitis in the affected eye that requires retreatment;
- * Requests for a newly affected eye should be reviewed under Section I above*
4. Member has not received \geq 16 weeks total of Oxervate treatment per affected eye(s);
 5. If request is for a dose increase, new dose does not exceed 1 vial per affected eye per day.

Approval duration: Up to a total of 16 weeks (lifetime 2 courses of treatment per affected eye)

B. Other diagnoses/indications (must meet 1 or 2):

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
 - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
 - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business:

- CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid, or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration

rhNGF: recombinant human nerve growth factor

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: Contraindications/Boxed Warnings

None reported

Appendix D: General Information

- Definitions of neurotrophic keratitis stages 1-3:
 - Stage 1: Punctate keratopathy and/or corneal epithelial hyperplasia and irregularity.
 - Stage 2: Persistent corneal epithelial defect (PED), typically oval or circular in shape, with smooth and rolled edges.
 - Stage 3: Corneal stroma and a corneal ulcer is observed. Corneal ulceration tends to progress to perforation and/or stromal melting if not promptly and properly treated.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Neurotrophic keratitis	1 drop in the affected eye every 2 hours six times a day for 8 weeks	6 drops per affected eye per day

VI. Product Availability

Ophthalmic solution: 0.002% (20 mcg/mL)

VII. References

1. Oxervate Prescribing Information. Milan, Italy: Dompe farmaceutici S.p.A; December 2024. Available at: <https://oxervate.com/wp-content/uploads/2025/01/OXERVATE-PI-Rev.-12-2024.pdf>. Accessed October 21, 2025.

2. European Medicines Agency, Science Medicines Health/Assessment Report. Updated May 18, 2017. Available at: https://www.ema.europa.eu/en/documents/assessment-report/oxervate-epar-public-assessment-report_en.pdf.
3. Cunha AM, Bunya V, Woodward N, et al. Neurotrophic Keratitis. Last updated August 18, 2024. Available at: https://eyewiki.aao.org/Neurotrophic_Keratitis. Accessed November 7, 2025.
4. Bonini S, Lambiase A, Rama P, et al. Phase II randomized, double-masked, vehicle-controlled trial of recombinant human nerve growth factor for neurotrophic keratitis. *Ophthalmology*. 2018;125:1332-1343.
5. Pflugfelder SC, Massaro-Giordano M, Perez VL, et al. Topical recombinant human nerve growth factor (cenegermin) for neurotrophic keratopathy: a multicenter randomized vehicle-controlled pivotal trial. *Ophthalmology*. 2020;127:14-26.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
1Q 2022 annual review: no significant changes; references reviewed and updated.	10.04.21	02.22
Template changes applied to other diagnoses/indications and continued therapy section.	10.05.22	
1Q 2023 annual review: for continued therapy added the following criteria to clarify maximum treatment duration: Member has not received ≥ 16 weeks total of Oxervate treatment per affected eye(s); clarified continued therapy approval duration limited to lifetime 2 courses of treatment <i>per affected eye</i> ; references reviewed and updated.	10.12.22	02.23
1Q 2024 annual review: added optometrist as an additional prescriber option; references reviewed and updated.	10.24.23	02.24
1Q 2025 annual review: no significant changes; references reviewed and updated.	10.22.24	02.25
1Q 2026 annual review: added diagnostic requirement for documented evidence of decreased corneal sensitivity; added requirement that disease is refractory to at least one conventional non-surgical treatment; for continuation of therapy, for a second 8 week treatment course added requirement that member did not achieve complete corneal healing or has recurrence of neurotrophic keratitis in the affected eye that requires retreatment; for initial approval criteria added requirement if member previously received Oxervate, member has not received ≥ 16 weeks total of Oxervate treatment per affected eye; references reviewed and updated.	10.21.25	02.26

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional

organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note:

For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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